Supervisor's Report of Work-Related Injury

University of Maryland Baltimore County

To be completed by the supervisor or higher authority and submitted with all other reports to Workers' Compensation

Employee Information

Injured Employee First Name

Injured Employee Last Name

Injured Employee Email

Date of Accident

Time of Accident

hh:mm AM/PM format

Employer/Supervisor Notified Date

Location

Bldg. and Area (hall way, office, etc)

Accident Details

describe the work-process you were engaged in, give the purpose of the function or task, describe how the injury occured, and explain the cause

Part of Body Injured

be specific - example: right middle finger, left ankle, upper back

Type of Injury

example; sprain, sutured, contusion, burn {degree of burn}

Describe any factors that may have contributed to the injury or illness

Number of days worked with restrictions

Witness Information

Name

Job Title

Phone

Name

Job Title

Phone

Name

Job Title

Phone

Information

Do you agree with the employee's description of the accident?

☐ **Yes** ☐ **No**

Was safety equipment provided?

☐ **Yes** ☐ **No**

Was safety equipment used?

☐ **Yes** ☐ **No**

Recommendation on how to prevent this accident from recurring

Name of Supervisor

Department of Supervisor

Work Phone Number

Email

☐ **By clicking checking this box and submitting this form to esh@umbc.edu I affirm the information provided above is accurate to the best of my knowledge and if I have questions I will contact UMBC ESH at esh@umbc.edu**